

IMPROVING

MENTAL HEALTH INSURANCE BENEFITS

Without INCREASING COSTS

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U.S. Department of Health and Human Services

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Executive Summary

uring any year, roughly a third of noninstitutionalized civilians between ages 15 and 54 have a mental disorder. Yet workers who are covered by employer health plans typically find that their benefits for mental health (MH) services are much more limited than those for medical/surgical care. As a result, many in need of MH services may be forced for financial reasons to forgo them or discontinue treatment prematurely. Mental health problems take a heavy toll on the American economy, costing billions of dollars each year in lost productivity and increased absenteeism.

This study suggests ways that MH benefits can be improved at little or no additional cost to employers. It is based on actuarial analysis, discussions with benefit design experts, and a review of the professional literature. Results show that health plans can keep the costs of MH benefit improvements to a minimum if they do the following:

- Provide financial incentives for substituting lower-cost alternatives (such as partial hospitalization or psychosocial rehabilitation) for higher-cost inpatient hospital care.
- Reduce employee cost sharing for outpatient services (which will encourage employees to seek treatment) by covering fewer outpatient visits (to keep total benefit costs the same).
- Employ a simple design that is easy to administer and easy for consumers to understand and follow.

- Cover treatment in intermediate settings (such as partial hospitalization) in preferred provider organization (PPO) and point-of-service (POS) plans only if the treatment is provided by network providers, where care can be managed.
- Increase coinsurance rates for PPO and POS enrollees who use non-network services (to encourage the use of network providers).

This report describes benefit packages that incorporate some of these principles and have actuarial values equivalent or similar to benefits packages typically offered by employers. Because employee enrollment is highest in health maintenance organizations (HMOs) and PPOs, modification to MH packages offered by these two delivery systems will have the most far-reaching effects. However, POS and indemnity plans would

benefit from improvements to their MH benefits as well.

The MH plans described in this report are still limited in scope compared with most medical/surgical coverage, and therefore are not meant as substitutes for parity in health/mental health benefits. These limited benefit packages do not provide adequate coverage for catastrophic mental illnesses,

and they require trade-offs (e.g., reducing covered outpatient visits to allow for lower employee cost sharing). Nevertheless, because they provide better benefits than those typically offered by employers, they hold the promise of increasing access to mental health services for millions of American workers and their families and of improving workplace productivity.

Introduction

mployer-sponsored health insurance plans typically provide less coverage for mental health (MH) services than for med-■ ical/surgical services. For example, many employer-sponsored health plans cover an unlimited number of inpatient hospital days for medical/surgical care, but allow only 30 to 60 days of inpatient hospitalization per year for MH care (Buck et al., 1999). In addition, outof-pocket costs are often higher for outpatient MH services than for outpatient medical/surgical care.

In response to this situation, the Federal Government and a number of States have begun to require that mental health services be covered in the same way as other medical care. This concept is known as "parity." Recent legislation designed to achieve parity, however, has had limited impact. Many of these laws do not cover all mental disorders or address only certain types of insurance benefit limits. Further, many employers are exempt from, or not subject to, such laws. Universal parity coverage for MH benefits may not be likely in the near future.

In the absence of legislative mandates, employers are not inclined to voluntarily increase the generosity of their MH benefits under current health insurance market conditions. Employers are already paying more than they once were for about the same level of benefits: data indicate that employer costs for health insurance benefits increased by about 6 percent in 1998 after a 5-year period of relatively flat growth, while the level of

health insurance benefits remained roughly the same as in previous years. Even larger cost increases are predicted for the future, at which time experts believe that employers will be inclined to decrease employee benefits rather than expand them (Bureau of National Affairs, 1999, 2000).

Purpose of This Report

This report provides employee benefits managers and purchasers with guidance on how to purchase MH insurance benefits that promote cost-effectiveness, access to treatment, and high-quality care (American Managed Behavioral Health Association, 1994; Frank, Goldman, & McGuire, 1992). It describes MH coverage that provides effective treatment regimens consistent with clinical studies and that have the same or close to the same actuarial value as benefit packages typically offered by employers. These packages incorporate design recommendations that are based on (1) input

from MH clinicians and benefit experts (see Appendix B), (2) analysis with an actuarial benefit model, and (3) a review of the literature. The report focuses on packages for health maintenance organizations (HMOs) and preferred provider organizations (PPOs) because these delivery systems have the highest employee enrollments. However, the benefit design recommendations can also be applied to point-of-service (POS) and indemnity plans.

MH benefit design is one of several issues that employers consider when purchasing behavioral health coverage. Employers also select the organization(s) that will administer these benefits, determine the level of service utilization management for health benefits, and decide whether to offer any additional services, such as an employee assistance program (EAP). Although employers' decisions about vendors, level of utilization management, and EAPs are important, they are beyond the scope of this study.

Many employers who offer limited MH benefits believe that these packages cover most of the MH expenses incurred by most employees and dependents. But for some individuals with chronic and relapsing serious mental disorders, limited MH benefits can mean extremely high out-of-pocket expenses.

This report's focus on limited MH benefits is not meant to imply that such packages are preferable to ones that establish parity—or equivalent coverage—for MH and medical surgical services. Limited benefit packages often do not provide adequate coverage for catastrophic mental illnesses. It is true that

if employers offer more generous MH benefits, their expenditures for these benefits will increase if the level of utilization management is unchanged. But research suggests that parity in managed behavioral carve-out plans and tightly managed HMO's would increase costs by a relatively small amount. Sturm (1997) estimates that costs for managed behavioral carve-out plans would increase by \$7 per enrollee per year. Sing, Hill, Smolkin, et al. (1998) estimate that total health insurance premiums for tightly managed HMO's would increase by less than 1 percent. Increases would be much greater in loosely managed PPO or indemnity plans—costs for covered mental health services could more than double, and total premiums could increase by about 5 percent (National Advisory Mental Health Council, 1998; Sing et al., 1998). Studies show that employers who switch from an unmanaged indemnity plan that limits MH benefits to a managed plan that offers parity have lower expenditures for MH benefits (National Advisory Mental Health Council, 1998; Sing et al., 1998).

Organization of the Report

This report is organized as follows: Chapter III describes the prevalence, impact, and treatment of mental disorders in the work-place. Chapter IV presents typical benefits packages for MH treatment; these packages are based on an actuarial analysis conducted by the Hay Group, a benefits and actuarial consulting firm. Chapter V presents benefit design recommendations. Finally, Chapter VI presents MH benefits packages for HMOs and PPOs that incorporate these recommendations and that have the same or close to the same actuarial value of MH benefits packages typically offered by employers.

¹ EAPs are designed to help in the early identification and resolution of employee problems (e.g., problems related to health, stress, finances, and alcohol abuse) that may impair job performance.

Mental Disorders in the Workplace: Prevalence, Impact, and Treatment

mployers may be able to improve productivity in the workplace by promoting the mental health of their employees. Indeed, research shows that employees with mental disorders have higher absenteeism and lower productivity than their colleagues, but that treatment can improve both measures (Berndt, Finkelstein, Greenberg, et al., 1998; Mintz, Mintz, Arruda, et al., 1992; Simon, Katon, Rutter, et al., 1998). This chapter describes the prevalence of mental disorders in the workplace and discusses how such disorders, left untreated, can adversely affect employee productivity. It concludes with a summary of the literature on effective treatments for mental disorders.

Mental Disorders Are Prevalent

Mental disorders are more prevalent than is commonly realized (Kessler, McGonagle, Zhao, et al., 1994). During any year, 30 percent of the noninstitutionalized civilian population age 15 to 54 have a mental disorder. Over their lifetime, 48 percent of the noninstitutionalized civilian population age 15 to 54 have had at least one disorder, and 27 percent have had two or more disorders. The most common mental disorders among this age group are depression, anxiety, and substance abuse. Specifically, they include the following:

■ *Major depressive episodes* occur in 10 percent of the population. Symptoms of

- depression can include decreased energy, fatigue, sleep disturbance, difficulty concentrating, indecision, daily feelings of worthlessness, and decreased pleasure or interest in activities.
- *Panic disorder*, the most debilitating anxiety disorder, affects 2 percent of the 15- to 54-year-old population. People with panic disorder have recurrent and unexpected panic attacks—short periods of intense fear that can include choking, dizziness, and nausea.
- *Generalized anxiety disorder*—excessive worry about many things—occurs in 3 percent of the 15- to 54-year-old population. It lasts for about 6 months and

- is difficult to control. Symptoms can include difficulty concentrating, irritability, and sleep disturbance.
- Social phobia, which occurs in 8 percent of 15- to 54-year-olds, is excessive or unreasonable fear and anxiety about social or performance situations. For people with social phobia, avoiding or anticipating feared situations can significantly interfere with normal functioning in occupational settings, social activities, or relationships.

Unfortunately, mental disorders are prevalent among children as well. One-fifth of the children in the United States have a diagnosable mental disorder, and 5 to 9 percent have a severe emotional disturbance with extreme functional impairment (Friedman, Katz-Leavy, Manderscheid, et al., 1996). Thirteen percent of children and adolescents have an anxiety disorder, 10 percent have a disruptive disorder, and 6 percent have a mood disorder (Shaffer et al., 1996).2 Two of the most common disorders among children are attention-deficit hyperactivity disorder (ADHD), found in 3 to 5 percent of the school-age population, and major depressive disorder, which affects 2 to 5 percent of adolescents (Burns, Hoagwood, & Mrazek, 1998). The core symptoms of ADHD include impulsivity, overactivity, and abnormally high levels of inattention, all of which often cause difficulty in a variety of settings.

Children and other dependents who have serious mental illnesses can affect their parents' (or other family members') attendance at work. For example, working parents of children with serious mental illnesses sometimes need time off from their jobs to care for their children or to take them to MH providers for treatment.

Mental Disorders Are Associated with Lower Employee Productivity

People with mental disorders have lower productivity and more problems on the job than do other employees. This is not surprising, since many of the symptoms of mental illness, such as fatigue, difficulty concentrating, indecision, irritability, and panic attacks, can constrain the ability to perform even the simplest of tasks. Indeed, part of the diagnostic definition of major depressive episode, generalized anxiety disorder, and social phobia is that the illness impairs social, occupational, and other important areas of functioning. Employees who exhibit more symptoms of mental disorders are absent from work about three times as often as are other employees (French & Zarkin, 1998).

Despite the debilitating effects of mental disorders, a large share of the people affected are employed, though their performance on the job is probably not what it could be. Seventy-two percent of people with depression are part of the workforce. Employees with major depression and those with panic disorder are more likely to miss work than are other employees (Broadhead, Blazer, George, et al., 1990; Kouzis & Eaton, 1997). One study estimated that in 1990, absenteeism and reduced productivity resulting from depression accounted for \$24 billion in financial losses to the economy (Greenberg, Stiglin, Finkelstein, et al., 1993). In the Global Burden of Disease study, Murray and Lopez (1996) found that major depression is second in disease burden, just behind ischemic heart disease, in established market economies. Furthermore, Conti and Burton

² The sum of these percentages exceeds 20 percent because some children and adolescents have two disorders simultaneously.

(1994) found that depression accounts for 3 percent of short-term disability claims and that claimants for depression are more likely to return to short-term disability status within a year than are claimants for other health conditions.

Like depression, social phobia can interfere with productivity. Studies suggest that this disorder is associated with performing below one's full potential (Lader, 1998). In a postindustrial economy, where interpersonal skills are increasingly important to job performance, social phobia may hinder productivity by interfering with an employee's ability to speak at meetings or to interact successfully with coworkers and customers.

The stress of caring for a child with mental illness may reduce a parent's capacity to perform well in the workplace, but studies have not quantified the impact of this stress on performance (Tessler & Gamache, n.d.).

Effective Treatments for Mental Disorders Are Available

Effective treatments for mental disorders are available and can improve functioning (Nathan & Gorman, 1998), but efficacy varies with the illness. For some mental disorders, certain treatments appear more effective than others. But for disorders such as major depression, it is not clear that one option is more effective than another.

Both psychotherapy and psychotherapeutic medications address the symptoms of major depression, generalized anxiety disorder, social phobia, and panic disorder. New medications with fewer side effects are also available for major depression, social phobia, and panic disorder.

Studies show that employees with major depression who began taking medications perceived their level of performance at work to significantly increase within 4 weeks (Berndt et al., 1998). Psychosocial therapy over a 12-week or 6-month period also does much to alleviate the symptoms of major depression or generalized anxiety disorder, but studies have not shown whether therapy or medications are more effective. For instance, among people with acute depression, absenteeism is reduced and productivity improves regardless of whether treatment consists of short-term medications, psychotherapy lasting 10 to 16 weeks, or maintenance therapy over 6 to 9 months (Mintz et al., 1992; Simon et al., 1998).

For social phobia, exposure therapies, in which patients are encouraged to repeatedly experience the situations they fear, are the most effective treatment. Panic disorder is effectively treated with therapy that combines education about the disorder with coping skills, exposure, and efforts to change thought patterns. Studies have also found that less intensive treatment, less frequent therapy sessions, or self-education with a manual can be as effective as more intensive treatment.

Both medication and therapy are effective in treating children with ADHD and children with depression (Burns, Hoagwood, & Mrazek, 1998; U.S. Surgeon General, 1999). Medications such as Ritalin reduce the symptoms of ADHD in 70 to 80 percent of affected children. Psychosocial treatment, including parent and teacher training in behavior modification, tends to improve targeted behaviors or skills but is more effective when combined with medications.

For adolescents with depression, cognitive behavioral therapy (short-term directive therapy designed to change negative views) appears to be an effective treatment. Research suggests that therapy can also help younger

children with depression. On the other hand, evidence is weak that nonhospital residential treatment facilities are effective for children with severe mental disorders. These licensed

facilities offer 24-hour treatment services and account for nearly one-fourth of national spending on child mental health treatment (U.S. Surgeon General, 1999).

Typical Benefits Packages for MH Treatment

his chapter describes typical employer-sponsored MH insurance benefits. These packages were selected from survey data collected by the Hay Group, a benefits and actuarial consulting firm. The Hay Group used an actuarial model it developed to compute the value of each MH package described in the survey and then identified as typical those with the median actuarial value.

The first section of the chapter discusses the MH treatment components of these health insurance benefit packages. The second section explains why most employers limit coverage for MH treatment. The third section describes the survey and actuarial model used to estimate the value of the health insurance packages. The last section describes MH benefits that are typical of median plans and looks at plans that are more and less generous than the median.

Benefit Design Components

Many components of health insurance plans can affect consumers' access to care, service use, out-of-pocket expenditures, quality of care, and health plan cost experience. The focus of this discussion is on the components over which employers have more direct control: covered services, maximum benefit limits, cost sharing, and maximum out-ofpocket expense limits.

Covered Services

A health plan pays for only those services included in the plan's list of covered services. In the case of mental health services, inpatient and outpatient treatment are most often covered by health plans. However, there is a continuum of services between inpatient and outpatient care that effectively treat many mental disorders and are often more cost-effective than inpatient care. These intermediate services include nonhospital residential services, partial hospitalization services, and intensive outpatient services such as case management and psychosocial rehabilitation.3 Case management involves coordinating and integrating services for patients who require services from two or more providers. Psychosocial rehabilitation includes pharmacologic treatment,

³ Data on the percentage of employer-sponsored health insurance plans that cover these services are presented in the last section of this chapter.

social skills training, and vocational rehabilitation. As discussed later in this chapter, intermediate services are covered by about half of employer-sponsored health plans.

Coverage of prescription medications is also important in providing access to treatment for mental disorders. Prescription medications are nearly always covered by health plans (U.S. Department of Labor, 1996; 1998), but this coverage is sometimes limited by formulary restrictions.

Maximum Benefit Limits

There are two types of maximum benefit limits: service limits and dollar limits. Service limits are the maximum number of outpatient visits or inpatient hospital days that will be paid for by the plan. Dollar limits are the maximum amount the plan will spend on services.

Limits may be on an annual or a lifetime basis, with annual limits the most common, especially for service limits. While the Mental Health Parity Act of 1996 does not require employers to offer MH benefits, it does prohibit firms with more than 50 employees that do offer such benefits from having lower dollar limits for mental health services than for medical/surgical services. However, the act does not preclude service limits for covered mental health services. Nor does the act apply to substance abuse benefits. Companies for which the legislation results in cost increases of 1 percent or more are exempt from the act.

Cost Sharing

Health plans generally require the consumer to pay part of the costs of services covered by the plan. Cost sharing can include copayments, coinsurance, and deductibles. Copayments are fixed dollar amounts that

the consumer must pay for each covered service used. For example, a health plan may require enrollees to pay \$20 per MH outpatient visit to a network provider. Coinsurance requires enrollees to pay a specific percentage of the charges approved by the plan after enrollees pay the deductible. The deductible is the amount of money enrollees must pay for charges approved by the plan before the plan will start paying for all or part of the remaining covered services.

For HMO, POS, and PPO plans, copayments, coinsurance rates, and deductibles are usually higher for services received from providers outside the plan's network. This feature provides enrollees with a financial incentive to seek care within the network of providers, where plans can manage service utilization.

Maximum Out-of-Pocket Expense Limits

Maximum out-of-pocket expense limits are a way of protecting consumers from catastrophic expenses. These limits are the maximum total amount of money consumers would have to pay for cost sharing for covered services during the year. For example, a typical maximum out-of-pocket expense limit for individual health insurance coverage was about \$1,600 in 1997 (U.S. Department of Labor, 1999).

Maximum out-of-pocket expense limits do not apply to services not covered by the health insurance plan. Therefore, they do not apply to outpatient or inpatient MH services that exceed the health plan's maximum service limit—often 30 outpatient MH visits and 30 inpatient MH days per year. Consequently, maximum out-of-pocket expense limits do not protect consumers from the most catastrophic expenses they

might face for MH treatment. An example of catastrophic expenses is repeated inpatient stays for mental illness that exhaust a 30-day limit on inpatient mental health care. Even with a maximum out-of-pocket limit, enrollees are liable for all charges incurred after 30 inpatient MH days.

Why MH Benefits Have Limits

Many employers restrict their coverage of MH insurance benefits to cap their financial liability. They also believe that the MH benefits they offer cover the bulk of MH treatment expenses incurred by most employees. Employers originally placed limits on MH insurance coverage to protect themselves financially. One widely cited study found that patients enrolled in indemnity plans use about twice as many outpatient mental health services (primarily psychotherapy) as outpatient medical/surgical services when their out-of-pocket costs for MH services fall (Newhouse, 1993).5 Until the 1990's, most employees were enrolled in traditional indemnity plans, which did not manage care, and benefit design was the primary way to contain costs. Consequently, most employers limited MH coverage to a maximum of 30 to 60 outpatient visits and

a maximum of 30 to 60 inpatient hospital days. They also imposed higher patient cost-sharing requirements for covered MH services than for covered medical/surgical services.

Although employers typically offer limited MH insurance benefits, many experts believe that these benefits cover most of the MH treatment expenses incurred by employees and their dependents.6 For instance, the average length of stay in a hospital for MH treatment is less than 10 days. Most people with mental disorders who require a hospital stay can be treated within a 30-day stay for the first episode of their illness. This period is within the 30 to 60 days typically covered by plans. Many people with depression or generalized anxiety disorders can be treated with psychotherapy over a 3- to 6-month period, also covered by many employer-sponsored health plans. Nearly all plans cover prescription medications, which are a critical component of much psychiatric treatment. But coverage for prescription medications is sometimes limited by formulary restrictions.

Certain mental health conditions require intensive treatment that is not completely covered by health plans. For example, in cases of serious mental illness such as schizophrenia, limited MH benefit packages often cover a person's first episode of treatment in a year, but not multiple episodes in a year. People with such treatment needs can incur catastrophic out-of-pocket expenses under these limited plans.

⁴ The source of information for most of this section comes from conversations with the benefit design experts, employers, and clinicians listed in Appendix B.

⁵ These results are not necessarily true for people who use inpatient MH care, who have serious mental illnesses such as bipolar mood disorder, or who have substance abuse disorders. The study, the RAND Health Insurance Experiment, did not include enough people with inpatient MH stays or serious mental illnesses to draw any inferences about their behavior.

⁶ See also U.S. Surgeon General, 1999, Chapter 6.

The Hay Group's Survey and Actuarial Model

In the spring of 1998, the Hay Group surveyed 1,017 employers and subsequently conducted an actuarial analysis of the survey data to identify the typical MH median benefit package and packages that are more and less generous than the median. The analysis itself is based on data from 1,002 employers who reported useable information. Participating employers were predominantly medium and large firms from a wide mix of industries located throughout the United States.

Employers identified the type of plan (HMO, POS, PPO, or indemnity) that had the highest employee enrollment in their firm. HMOs manage care by covering only care received from network providers. Many HMOs require enrollees to obtain approval from a gatekeeper (who is usually a primary care physician in the network) before receiving care from a specialist in the network. Under POS plans, enrollees may obtain covered services from network or non-network providers, but they incur higher costs when they seek care outside the network. Enrollees in POS plans are required to obtain approval from a gatekeeper before using non-network services.

PPOs allow enrollees to obtain services from network providers or non-network providers without permission from a gatekeeper. To encourage the use of network providers, PPOs cover a larger share of out-of-pocket costs when their enrollees stay in network.

Survey participants gave information on the design of their benefit package that had the highest employee enrollment. Ultimately, they provided data on packages for 259 HMOs, 200 POS plans, 381 PPOs, and 139 indemnity plans. In addition, there are data for 23 managed behavioral health organizations (MBHOs) that contract directly with employers.7

To estimate the actuarial value of the MH benefit packages described in the survey, the Hay Group used its Mental Health Benefit Value Comparison (MHBVC) model. This model has been used by the National Institute of Mental Health (NIMH), the Congressional Research Service, and firms in the private sector.

The actuarial values of the MH benefit packages described in this report are estimates of health plan expenditures, including the health plan's administrative costs per adult for a typical population of insured employees and their dependents. To compute the actuarial value of a benefit package, the MHBVC model relies on distributions of actual health care claims data for several types of services (such as inpatient and outpatient mental health and substance abuse treatment). For HMO, POS, PPO, and indemnity plans, the MHBVC model determines how much the health plan would pay for each patient in a distribution, based on the services covered by the plan and the plan's service limits and cost-sharing requirements. The model includes assumptions about administrative costs, level of utilization management in each plan, and consumer responses to changes in out-of-pocket costs. The model then calculates a weighted average across consumers.

Using this information from the MHBVC, the Hay Group identified—separately for HMO, POS, PPO, and indemnity plans—

⁷ MBHO's appear to be undercounted in this survey because a significant number of respondents did not answer the question regarding whether their MH benefits were provided by an MBHO.

typical benefit packages at or near the 25th percentile ("less generous" benefit packages), the 50th percentile ("median" benefit packages), and the 75th percentile ("more generous" benefit packages) of the distribution of actuarial values. (More details about the Hay Group's survey and the MHBVC are in Appendix A.)

Typical MH Benefit Packages

Compared with information about MH benefit packages presented in other studies, the packages described here are a better measure of typical MH benefits, because the estimates of the packages' actuarial value account for all benefit components (such as covered services, service limits, and cost-sharing requirements) and how these components interact with one another. Other studies that have examined typical MH benefit packages reported on each component separately, describing, for example, the median service limit, the median cost-sharing requirement, and the median annual or lifetime spending limit separately for each covered service (e.g., Buck, Teich, Umland, et al., 1999). The problem with this approach is that median values for each component do not necessarily translate into the median actuarial value of the benefit package as a whole. For example, plans with more generous cost sharing may have lower maximum day or visit limits than plans with less generous cost sharing. Or a benefit package with more generous outpatient coverage and less generous inpatient coverage could have a median actuarial value.

The actuarial values in this study account for (1) cost sharing and maximum benefit limits and (2) benefit provisions for both mental health and substance abuse treatment services. For POS and PPO plans, the actuarial values account for both in-network and out-of-network benefits.

Typical Benefit Packages by Plan Type

In 1998, the highest percentage of employees (40 percent) were enrolled in PPOs, which tend to manage utilization loosely. HMOs, which tend to manage utilization tightly, enrolled 29 percent of employees. About 13 percent of employees were enrolled in indemnity plans and 16 percent were in POS plans (William M. Mercer, Inc., 1999).8 The less generous, median, and more generous benefit packages for PPO, HMO, POS, and indemnity plans based on the Hay Group actuarial model and survey are presented in Tables 1 through 4.9

For most plan types, the primary reason for differences between more and less generous plans is cost sharing (coinsurance rates) for outpatient and inpatient care. Coinsurance rates for outpatient visits range from 30 to 90 percent. The impact of differences in inpatient coinsurance rates on plan and employee costs is greater than the impact of differences in outpatient rates, even though the range of differences is narrower (60 to 100 percent). Small differences in inpatient coinsurance rates have a greater impact on the actuarial values relative to outpatient coinsurance rates because of the greater cost of inpatient care.

⁸ How many of these health plans subcontracted MH services to MBHO's or how many employers directly contract with MHBO's was not reported.

⁹ The Hay Group also collected data on the benefit package of MBHO's, but because a significant number of survey respondents did not answer the question regarding whether MH benefits were provided by an MBHO, the data for MBHOs are not reported here.

Table 1: Typical PPO Benefit Packages

	Less generous¹	Median	More generous
Inpatient day limit	28	30	30
Inpatient coinsurance (paid by patient) ²			
In-network	10%	0	0
Out-of-network	30%	20%	20%
Outpatient visit limit	20	30	30
Outpatient coinsurance			
In-network	50%	50%	10%
Out-of-network	70%	70%	30%
Actuarial value ³	\$65	\$80	\$94

- 1. Less generous = typical plan at the 25th percentile of the distribution of actuarial values within plan type. More generous = typical plan at the 75th percentile of the distribution of actuarial values within plan type.
- 2. All copayments were converted to coinsurance rates.
- 3. Actuarial values are in 1998 dollars and represent the annual premium for a single adult employee.

Source: The Hay Group's Mental Health Benefit Value Comparison model and 1998 survey of employers. Based on 381 PPOs.

PPOs

For PPOs, the major difference between more and less generous MH benefit packages is in outpatient coverage (Table 1). The less generous PPO benefit package pays half the cost of up to 20 outpatient visits in-network but only 30 percent of the cost for out-of-network visits. The median PPO benefit package pays the same coinsurance rate for outpatient care as does the less generous package, but

for more visits. The more generous PPO benefit package pays for 90 percent of the cost of up to 30 visits in-network and 70 percent of the cost for out-of-network visits. The less generous PPO benefit package also requires some cost sharing for inpatient care and covers slightly fewer days than the other PPO benefit packages.

Table 2: Typical HMO Benefit Packages

	Less generous'	Median	More generous
Inpatient day limit	30	30	30
Inpatient coinsurance (paid by patient) ²	0	0	0
Outpatient visit limit	30	30	30
Outpatient coinsurance	50%	20%	10%
Actuarial value ³	\$41	\$51	\$58

- 1. Less generous = typical plan at the 25th percentile of the distribution of actuarial values within plan type. More generous = typical plan at the 75th percentile of the distribution of actuarial values within plan type.
- 2. All copayments were converted to coinsurance rates.
- 3. Actuarial values are in 1998 dollars and represent the annual premium for a single adult employee.

Source: The Hay Group's Mental Health Benefit Value Comparison model and 1998 survey of employers. Based on 259 HMOs.

HMOs

The only difference among the three HMO benefit packages in Table 2 is in outpatient cost sharing, which typically takes the form of copayments (fixed dollar amounts). The Hay Group model converts copayments into effective coinsurance rates (see Appendix A). The effective coinsurance

rates in the typical HMO packages examined here range from 50 percent for the less generous package to 90 percent for the more generous package. All three HMO benefit packages cover 30 outpatient MH visits and pay for the entire cost of 30 days of inpatient care.

Table 3: Typical Point-of-Service Plan Benefit Packages

	Less generous¹	Median	More generous
Inpatient day limit	30	30	60
Inpatient coinsurance (paid by patient) ²			
In-network	20%	0	0
Out-of-network	40%	20%	20%
Outpatient visit limit	20	30	30
Outpatient coinsurance			
In-network	10%	20%	10%
Out-of-network	30%	40%	30%
Actuarial value ³	\$74	\$88	\$103

- 1. Less generous = typical plan at the 25th percentile of the distribution of actuarial values within plan type. More generous = typical plan at the 75th percentile of the distribution of actuarial values within plan type.
- 2. All copayments were converted to coinsurance rates.
- 3. Actuarial values are in 1998 dollars and represent the annual premium for a single adult employee.

Source: The Hay Group's Mental Health Benefit Value Comparison model and 1998 survey of employers. Based on 200 point-of-service plans.

POS Plans

POS benefits differ in both inpatient and outpatient coverage (Table 3). The less generous POS benefit package pays 80 percent of inpatient stays up to 30 days in-network and 60 percent of inpatient stays out-ofnetwork. It also pays up to 90 percent of

20 outpatient in-network visits and 70 percent of out-of-network visits. The more generous POS benefit package covers up to 60 days of in-network inpatient care in full, and pays most of the cost of up to 30 visits in-network.

Table 4: Typical Indemnity Plan Benefit Packages

	Less generous¹	Median	More generous
Inpatient day limit	30	30	120
Inpatient coinsurance (paid by patient) ²	20%	10%	20%
Outpatient visit limit	30	30	50
Outpatient coinsurance	50%	20%	20%
Lifetime limit	\$25,000	no limit	\$100,000
Actuarial value ³	\$83	\$104	\$127

- 1. Less generous = typical plan at the 25th percentile of the distribution of actuarial values within plan type. More generous = typical plan at the 75th percentile of the distribution of actuarial values within
- All copayments were converted to coinsurance rates.
- 3. Actuarial values are in 1998 dollars and represent the annual premium for a single adult employee.

The Hay Group's Mental Health Benefit Value Comparison model and 1998 survey of employers. Based on 139 indemnity plans.

Indemnity Plans

Unlike the PPO, HMO, and POS benefit packages, the median and more generous indemnity packages do not pay all covered charges for inpatient care (Table 4). Indemnity plans tend to use cost sharing to constrain service use because they are less able than the other types of plans to manage care with utilization management techniques.

Also unlike other plan types, some indemnity plans impose maximum dollar limits on benefits. At the time of the Hay Group survey in 1998, not all employers were subject to the Mental Health Parity Act of 1996, so some benefit packages had maximum dollar benefits limits

below those typical for medical/surgical benefits.10

Typical indemnity benefits differ in both inpatient and outpatient coverage. The less generous package pays 80 percent of inpatient stays up to 30 days and half the cost of up to 30 outpatient visits. It also limits lifetime benefits to \$25,000. The more generous indemnity benefit pays 80 percent of up to 120 days of inpatient care and 80 percent of the cost of up to 50 outpatient visits. It also limits lifetime benefits to \$100,000.

¹⁰Other data indicate many employers have raised their dollar limits to comply with the act or were already in compliance in 1998 (Substance Abuse and Mental Health Services Administration, 1999).

Table 5: Covered Intermediate Care Services by Type of Plan

	Percent d	of plans covering each	type of service	
	PPO (n=1,514)	HMO (n=1,209)	POS (n=795)	Indemnity (n=768)
Mental health				
Inpatient psychiatric care	96	88	95	94
Nonhospital residential	52	50	56	51
Intensive nonresidential	63	60	64	65
Outpatient therapy	86	84	87	87
Crisis-related services	49	55	56	33

Note: Excludes plans not covering any MH treatment services.

Source: Buck et al. (1999).

Covered Services

All of the typical benefit packages examined in this report cover inpatient and outpatient MH treatment services. Hay Group data could not be used to report on the coverage of intermediate MH treatment services such as nonhospital residential and partial hospitalization services because most employers responding to the survey did not answer questions about such coverage. However, another survey, the National Survey of Employer-Sponsored Health Plans, did collect data on coverage of residential and intensive nonresidential services

(Buck et al., 1999; William M. Mercer, Inc., 1999) from a nationally representative sample of employers. Because data from this survey are proprietary, the Hay Group model could not be used to compute actuarial values for them. Consequently, the only MH benefits survey data with sufficient detail for analysis with the model were the data collected by the Hay Group. Table 5 shows the percentage of plans that provide intermediate service coverage, as reported by the National Survey of Employer-Sponsored Health Plans.

Improving MH Insurance Benefit Design

he benefit design recommendations presented in this chapter are based on a review of the literature and discussions with MH clinicians and insurance benefit design experts (see Appendix B). The chapter concludes with a discussion of catastrophic coverage.

MH Benefit Design Recommendations

MH benefit packages should be cost-effective and promote access to treatment and highquality care (American Managed Behavioral Health Association, 1994; Frank, Goldman, & McGuire, 1992). To achieve these goals, these packages should have the characteristics described below.

Cover a Wide Range of Clinically Effective Services and Treatments

A well-designed benefit package should cover a wide range of clinically effective services and treatments while incorporating financial incentives to substitute lower cost alternatives for higher cost alternatives when it is clinically appropriate to do so (Frank et al., 1996). As discussed in Chapter IV, the vast majority of employer-sponsored plans cover inpatient and outpatient MH treatment services. Roughly half of all employers cover intermediate MH treatment services such as residential treatment and partial (or day) hospitalization. Approximately 60 percent

cover intensive outpatient services, which can include psychosocial rehabilitation, case management, and wraparound services for children.11

Intermediate treatment services are an effective, lower cost alternative to inpatient hospital treatment in many cases, so some believe employers should also cover these services (Frank et al., 1996; U.S. Surgeon General, 1999). One way to add such services without significantly increasing costs is to offer them as a trade-off for inpatient care. According to the MH benefit design experts consulted for this report, 1 day of treatment in an inpatient MH setting costs about the same as 2 to 3 days of residential treatment or 2 days of partial hospitalization treatment.

¹¹Psychosocial rehabilitation services include pharmacologic treatment, social skills training, and vocational rehabilitation. Case management involves coordinating and integrating services for patients who require services from two or more providers. Wraparound services for children include developing treatment plans for children that involve their families.

Although 1 inpatient day can be traded for more than 2 days of treatment in some intermediate settings (such as residential treatment), using the same rate of trade for all intermediate settings is simpler to administer and remember. Therefore, the experts recommend benefit packages in which 1 day of MH inpatient treatment can be traded for 2 days of treatment in an intermediate setting. Many employers currently offer MH benefits that permit trade-offs between inpatient and intermediate care.

The advantage of allowing enrollees to trade 1 day of inpatient care for 2 days of treatment in intermediate settings is that their treatment is covered for a longer period (if needed), thereby reducing the likelihood of relapse. There is also generally less stigma associated with intermediate care settings than with inpatient settings.

Inpatient treatment should be traded for treatment in intermediate settings only when patients and their provider are quite certain that the traded inpatient days will not be needed—a more likely situation toward the end of the benefit year.

Reduce Enrollee Cost-Sharing Requirements

The design experts felt very strongly that MH benefit design should promote access to care. A primary reason why the need for MH treatment is largely unmet is that most people with mental disorders do not seek professional treatment. According to one study, less than 20 percent of people with a recent mental disorder had obtained treatment within the previous 12 months, and less than 40 percent of people with a lifetime disorder ever receive professional treatment (Kessler et al., 1994).

Given these numbers, it stands to reason that MH benefits can be improved by

promoting access to treatment for those who need it but do not seek it. Promoting access means removing barriers to treatment. These barriers include patient out-of-pocket costs that are typically higher for MH services than for medical/surgical services and the stigma associated with having a mental disorder and receiving treatment for it (Simon, Grothaus, Durham, et al., 1996).

To encourage access to treatment with little or no increase in MH benefits costs to employers, the experts recommended reducing both patient cost-sharing requirements for outpatient MH services and service limits in order to pay for the more generous coverage per visit. For example, as indicated in Chapter IV, the less generous HMO plan covers 30 outpatient MH visits at a patient coinsurance rate of 50 percent. To promote access to treatment with little or no increase in costs, these benefits could be modified so that 20 visits are covered (instead of 30) at a patient coinsurance rate of 40 percent (instead of 50 percent).

Alternatively, many experts recommend using progressively tiered patient coinsurance rates for outpatient services to promote access to care. Under a tiered copayment or coinsurance benefit design, the out-ofpocket cost for a particular outpatient MH visit depends on how many visits the patient has already made during the benefit year. The patient's out-of-pocket costs for the first few visits (e.g., the first three to five visits) would be lowest, and costs would increase with additional visits. For example, the first 3 visits could cost the patient nothing out-of-pocket, the next 10 visits could cost the patient \$20 out-of-pocket, and any remaining covered visits could cost \$30 out-of-pocket.

Some employers have already used progressively tiered copayment schedules (Goldman, McCulloch, & Sturm, 1998). These schedules appear to work best when the health plan administering the benefits has an information system that can effectively handle this type of benefit design. Without the proper information systems capability, this design can be difficult to administer because it is hard for health plans to correctly identify an enrollee's first three or five visits. Sometimes providers submit bills out of order; that is, they may submit a bill for the fifth visit before they submit a bill for the third visit. Also, providers may bill for a group of services, which can include two or more visits by an enrollee.

Use a Simple Benefit Design

Simple MH benefit packages are easier for enrollees to understand and use, resulting in less confusion. They are also easier for health plans to administer.

Use the Same Design for Mental Health and Substance Abuse

Although the focus of this report is on MH benefits, health plans should have the same service limits, cost-sharing requirements, and dollar spending limits for covered substance abuse services as they do for covered mental health services. The result is a simpler benefit design that employees and dependents can better understand. Another reason for using the same benefit design for mental health and substance abuse treatment services is that, in any year, about 10 million people in the U.S. have co-occurring mental and substance abuse disorders. It is difficult to administer benefits for people with these cooccurring disorders if mental health benefits are different from those for substance abuse.

Finally, making mental health and substance abuse benefits the same eliminates one incentive for "diagnosis code creep"—the practice whereby providers treat patients for a disorder that is not covered (such as substance abuse) but record, for billing purposes, a diagnosis code for treatment that is covered (such as mental health) to secure better coverage for the patient and better reimbursement for the provider.

Cover Intermediate Services Only from Network Providers

Treatment in intermediate settings should be covered only if it is administered by network providers because some intermediate services are overused when utilization is not managed. For example, many patients remain in custodial care facilities (such as residential treatment and nursing homes) much longer than necessary if the service is covered by insurance and not properly managed. However, in many cases, residential treatment can be a very cost-effective alternative to inpatient hospital care and should be covered if it is well-managed.

Encourage the Use of Network Providers in PPO and POS Plans

MH benefit packages can be modified in several ways to encourage the use of network providers in PPO and POS plans. First, they should incorporate financial incentives. One such incentive would be to increase the difference in coinsurance rates for innetwork services versus non-network services. Typically, there is a 20 percentage point difference in the coinsurance rate for network services compared with non-network services for PPO and POS plans (see Chapter IV, Tables 1 and 3). Increasing this difference to 30 or 40 percentage points would promote

greater use of in-network providers. Many employers have modified their MH benefits in this manner.

The use of network providers can also be increased if enrollees are assured of easily accessible, high-quality care. For example, providers should be conveniently located for enrollees, and plans should offer an adequate continuum of care.12

Catastrophic Coverage

One of the main purposes of health insurance is to protect individuals from catastrophic financial expenses (Frank, Goldman, & McGuire, 1996; U.S. Surgeon General, 1999). Although the vast majority of employees and dependents covered by employer-sponsored MH benefits have relatively small expenses for MH treatment (U.S. Surgeon General, 1999), some have chronic, relapsing serious mental illnesses that can result in excessively high costs. And while many employer-sponsored medical/surgical benefit packages provide catastrophic protection, limited MH packages do not. The former remove MH service limits, cover a wide range of clinically effective treatments and

services, have high annual and/or lifetime spending limits (such as a \$1 million lifetime spending limit), and impose annual maximum on out-of-pocket expenses for covered MH services (such as \$2,000 per year).

In contrast, a limited MH benefit package might cover only 30 inpatient and 30 outpatient visits per year. As noted in Chapter II, MH packages that provide catastrophic coverage will cost more unless employers switch from limited MH benefits in a loosely managed delivery system to more generous MH benefits in a more tightly managed system. While estimates indicate that employers will incur relatively small cost increases if they implement parity in tightly managed delivery systems (Sing et al., 1998; Sturm, 1997), the increases will be much greater in unmanaged or loosely managed plans. In fact, the costs for the latter could more than double, and total health insurance premiums could increase by about 5 percent (National Advisory Mental Health Council, 1998; Sing et al., 1998).

When MH benefits are limited, the challenge for employers and benefit design consultants is to incorporate the recommendations presented in the first section of this chapter without spending any more money on MH insurance benefits. The next chapter presents MH benefit packages that do so with little or no increase in cost.

¹² A discussion of criteria for MH provider networks is beyond the scope of this report. See Kushner and Moss (1995) for more information on purchasing managed behavioral services.

MH Benefits Packages That Incorporate the Recommendations

his chapter presents improved employer-sponsored MH benefits packages for HMOs and PPOs that incorporate the design recommendations in Chapter V. Essentially, these packages are modified versions of the typical packages presented in Chapter IV. They promote greater access to MH care with little increase in actuarial value. The key features of the enhanced packages are summarized in the following paragraphs, and are contrasted with the typical packages in Tables 6 and 8.

A Wider Range of Services Is Covered

The improved MH benefits packages cover intermediate care services such as crisis residential treatment, partial hospitalization, case management, and psychosocial rehabilitation. In many cases, these services provide effective treatment that costs less than inpatient hospitalization. But because some of these services can be overused in an unmanaged delivery system, they are covered only when administered by network providers.

Many employers now offer coverage for intermediate services. The benefit design experts consulted for this report believe that employers who do not offer such coverage could modify their MH benefits package to do so relatively easily. Including these additional services slightly increases the actuarial value of the typical benefits packages described in Chapter IV. According to the Hay Group model, the estimated increase would be

\$4 (in 1998 dollars) per year for a single adult employee for PPOs and \$2 per year for HMOs. This slight increase in actuarial value is due to greater use of services anticipated as a result of treatment options available under the improved packages: When people have more options, they tend to seek more treatment. By this reasoning, employees with mental disorders who are not now seeking treatment (or who are not complying with their prescribed treatment regimens) might do so, leading to better outcomes in terms of mental health and, by extension, job productivity.

Lower Patient Cost-sharing Requirements Promote Access to Outpatient MH Care

In the improved MH benefits packages, access to outpatient MH care is promoted, when possible, with lower patient cost-sharing requirements. The lower cost-sharing requirements are accompanied by lower service limits and/or by a larger difference between innetwork and out-of-network cost sharing so that there is little or no change in actuarial value.

Lower cost-sharing requirements are incorporated only when a package's actuarial value with this change and with the addition of intermediate service coverage does not increase the cost of the package by more than 5 percent. If MH benefits are 5 percent of total health care benefit costs, a 5 percent increase in MH benefit costs results in a 0.25 percent increase in total health care benefit costs, holding everything else constant.13 Cost-sharing requirements can therefore be lowered for the less generous PPO plans, but not for other plans because reducing patient cost sharing in a cost-neutral manner usually implies relatively large reductions in covered service limits (or higher patient out-of-pocket costs for inpatient treatment). Most people

The difference in the actuarial values of the improved MH benefits packages relative to typical benefits packages is based on typical MH packages that do not cover intermediate care services such as partial hospitalization. ¹⁴ However, many employer-sponsored benefits packages cover these services. These employers could modify their packages by specifying lower patient out-of-pocket costs and service limits for outpatient MH services to enhance employee access to treatment.

who use outpatient MH services have 10 or fewer visits per year. A relatively small proportion have 20 or more visits per year. According to the Hay Group model, the decrease in the actuarial value of an MH benefit resulting from a reduction in service limits from 30 visits to 25 visits is less than the increase in actuarial value resulting from a reduction in patient cost-sharing requirements from 50 percent to 40 percent in a PPO (or from 20 percent to 10 percent in an HMO).

¹³ MH benefits constitute approximately 5 percent of the total actuarial value of health insurance benefits.

¹⁴ Covering these services slightly increases the actuarial value of the MH benefit, as explained above.

Table 6: Typical PPO Benefit Packages

	Less generous	Median	More generous
Inpatient day limit	28	30	30
Inpatient coinsurance (paid by patient)			
In-network	10%	0	0
Out-of-network	30%	20%	20%
Outpatient visit limit	20	30	30
Outpatient coinsurance			
In-network	50%	50%	10%
Out-of-network	70%	70%	30%

Table 7: Modified PPO Benefit Packages

	Less generous	Median	More generous
Inpatient day limit	28	30	30
Inpatient coinsurance (paid by plan) In-network: 1 inpatient day may be traded for 2 days of either crisis residential services, partial hospitalization, and/or psychosocial rehabilitation	10%	0	0
Out-of-network	40%	20%	20%
Outpatient visit limit Outpatient coinsurance	15	25	30
In-network	40%	50%	10%
Out-of-network	70%	70%	30%

Table 8: Typical HMO Benefit Packages

	Less generous	Median	More generous
Inpatient day limit	30	30	30
Inpatient coinsurance (paid by patient)	0	0	0
Outpatient visit limit	30	30	30
Outpatient coinsurance	50%	20%	10%

Table 9: Modified HMO Benefit Packages

	Less generous	Median	More generous
Inpatient day limit: 1 inpatient day may be traded for 2 days of either: crisis residential services, partial hospitalization, and/or psychosocial rehabilitation	30	30	30
Inpatient coinsurance (paid by patient) Outpatient visit limit Outpatient coinsurance	0 30 50%	0 30 20%	0 30 10%

Appendix A: The Hay Group's Mental Health Benefit Value Comparison Model

he Hay Group's Mental Health Benefit Value Comparison (MHBVC) model estimates the value of mental health and substance abuse (MH/SA) insurance benefits on the basis of assumptions about the delivery, management, and use of MH/SA services. This appendix describes the key assumptions for this model.

Types of Cost Sharing and Maximum Benefit Limits

Patient out-of-pocket costs in a benefits package can be expressed in terms of coinsurance rates or copayments (fixed dollar amounts). In addition, some plans have a maximum fee that they will pay per visit, which is sometimes called a maximum allowable charge. The MHBVC model converts copayments and maximum fees per visit into effective coinsurance rates. The effective coinsurance rate is based on the average charge per visit:

(A.1) Effective coinsurance rate = coinsurance rate × (maximum fee per visit ÷ average per visit charge)

and

(A.2) Effective coinsurance rate = copayment ÷ average charge per visit

The MHBVC converts maximum dollar limits to effective visit limits using the same per visit charge:

(A.3) Effective visit limit = maximum dollar limit ÷ average charge per visit

The model uses an average charge per visit of \$109 for outpatient psychiatric visits.

Some plans in the Hay Group survey have lower dollar limits for mental health services than for medical/surgical services. There are two reasons for this. First, the Mental Health Parity Act of 1996 became effective for plan years starting January 1, 1998, or later, and not all of the plans in the Hay Group survey had begun new plan years. Second, some of the employers were exempt because they had 50 or fewer employees or were government agencies.

Similarities in Substance Abuse and Mental Health Benefits

The Hay Group survey collects detailed information about the coverage of mental health benefits and also asks whether coverage for inpatient substance abuse treatment is the same as coverage for inpatient mental health care. If they are different, the survey asks for the maximum benefit limits for substance abuse. Substance abuse and mental health benefits are almost always the same for plans in the Hay Group survey. Therefore, the typical benefits packages presented in Tables 1 through 4 do not have different benefits for mental health and substance abuse services.

PPO and POS Plans

The model incorporates three features of PPO and POS plans: (1) coverage of both in-network and out-of-network services, (2) network provider discounts, and (3) effects of utilization management by POS gatekeepers. Enrollees in PPOs and POS plans pay lower out-of-pocket costs when they use network providers, and these lower costs are incentives to remain in network. The Hay Group survey does not collect information about out-of-pocket cost sharing in these plans. Therefore, the model assumes that coinsurance is 20 percent lower for out-of-network services. For plans with a general deductible, the model assumes the deductible doubles for out-of-network services. For plans without a deductible, the model assumes the out-ofnetwork deductible is \$100. The MHBVC model assumes that 70 percent of care is from network providers.

Providers in PPO and POS networks agree to charge a discounted price for the services they provide to enrollees. The model assumes that this discount is 15 percent, which is consistent with discounts of 10 to 20 percent obtained by PPOs offered by two large national insurers (Verri & Zuckerman, 1996).

Many enrollees in POS plans are assigned a primary care provider called a gatekeeper. The gatekeeper must authorize all innetwork services (Jensen et al., 1997). The model assumes that POS plans reduce innetwork service use by 12 percent as a result of services denied by gatekeepers. It also assumes that out-of-network service use increases by 15 percent because some POS plan enrollees will seek treatment out of network (and pay higher cost-sharing amounts) when the gatekeeper denies innetwork treatment. Enrollees in PPOs can self-refer to any provider they wish to see.

Amount of Utilization Management

The model assumes that management of MH/SA services is more aggressive than management of medical/surgical services. For indemnity, PPO, and POS plans, the model assumes that, on average, the management of MH/SA services leads to a 25-percent reduction in costs compared with no management.

The model assumes that HMO's subcontract with managed behavioral health organizations that aggressively manage care and yield large cost savings. To compute the actuarial values of HMO benefits packages, the model uses different data on the distribution of health care expenditures by type of service compared with indemnity, PPO, and POS plans. A utilization management factor is not needed to compute the value of HMO benefits packages because the health expenditure data used to compute the value

of HMO benefits already incorporate the effects of utilization management.

These assumptions are consistent with the broad range of experience with managed behavioral health organizations. Frank and McGuire (1995) and Frank et al. (1995) discuss the literature on the impact of managed care on MH/SA expenditures and conclude that much uncertainty remains. Some large employers that had high MH/SA expenditures before subcontracting with a managed behavioral health organization, such as Xerox, realized significant savings (Xerox cut costs by about 40 percent). Frank and McGuire (1995) doubt that most employers would have such large cost reductions, because case studies that find large savings often reflect experiences of employers that had the highest costs and little or no utilization management before subcontracting.

Consumers' Responses to Changes in Their Out-of-Pocket Costs

People enrolled in plans with relatively low copayments or low coinsurance rates pay a lower price for the use of MH/SA services than do people in plans with higher copayments or coinsurance rates. The "induced demand" effect is the extent to which consumers use more MH/SA services in response to lower prices for these services (or use fewer services when the price is higher). In the MHBVC model, the Hay Group bases its assumptions about the extent of induced demand on data from the RAND Health Insurance Experiment (Newhouse, 1993). The RAND experiment measured consumer responsiveness to changes in the prices of medical/surgical and MH/SA services in unmanaged indemnity plans. Indemnity plans were the predominant delivery system in the 1970's when the RAND experiment

was conducted, but today, managed care plans such as HMO, PPO, and POS plans are more prevalent. The measures of consumer responsiveness to price changes computed from the RAND experiment overstate consumer responsiveness in managed care systems in which consumer demand for health services is constrained by the utilization management efforts of managed care plans.

Medical Cost Offset Effect

A medical cost offset effect occurs when treatment of an MH/SA disorder leads to a reduction in expenditures for medical/surgical services and when a portion of medical care use is driven by psychological or psychiatric factors. On the basis of a literature review conducted by Olfson et al. (1999) for this project, the model assumes there is no aggregate medical cost offset when someone switches from a median MH/SA benefits package to a more generous MH/SA benefits package.

Administrative Costs

The MHBVC's assumptions about administrative costs are based on a 1994 Hay Group study for the Congressional Research Service (Hay/Huggins Company, Inc., 1997). For indemnity, PPO, and POS plans, administrative expenses are assumed to be 11 percent above expenditures for services. On advice from experts, it is assumed that HMOs have higher administrative costs—especially for MH/SA treatment services—that average 20 percent above expenditures for services (Sing & Hill, 1998).

Limitations of the Survey Data

The Hay Group survey was mailed to firms that had participated in previous surveys as well as other firms that the Hay Group

Table 6: Typical PPO Benefit Packages

	Less generous	Median	More generous
Inpatient day limit	28	30	30
Inpatient coinsurance (paid by patient)			
In-network	10%	0	0
Out-of-network	30%	20%	20%
Outpatient visit limit	20	30	30
Outpatient coinsurance			
In-network	50%	50%	10%
Out-of-network	70%	70%	30%

Table 7: Modified PPO Benefit Packages

	Less generous	Median	More generous
Inpatient day limit:			
1 inpatient day may be traded for 2 days of either: crisis residential services, partial hospitalization, and/or psychosocial rehabilitation	28	30	30
Inpatient coinsurance (paid by patient)			
In-network	10%	0	0
Out-of-network	40%	20%	20%
Outpatient visit limit	15	25	30
Outpatient coinsurance			
In-network	40%	50%	10%
Out-of-network	70%	70%	30%

Table 8: Typical HMO Benefit Packages

	Less generous	Median	More generous
Inpatient day limit	30	30	30
Inpatient coinsurance (paid by patient)	0	0	0
Outpatient visit limit	30	30	30
Outpatient coinsurance	50%	20%	10%

Table 9: Modified HMO Benefit Packages

	Less generous	Median	More generous
Inpatient day limit:			
1 inpatient day may be traded for 2 days of either: crisis residential services, partial hospitalization, and/or psychosocial rehabilitation	30	30	30
Inpatient coinsurance (paid by patient)	0	0	0
Outpatient visit limit	30	30	30
Outpatient coinsurance	50%	20%	10%

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NOTE: The organizations identified for the individuals listed were as of the time of the project and do not necessarily indicate current affiliations.

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